Uniform Stamp Application

Name (last) (first) (middle initial)	Please check **one** ❑ New Applicant ❑ Recertification	CA Medical License Number (Physicians Only)
Employer Name (if not-self employed)		

Employer Address	City	State	ZIP code
Mailing Address	City	County	ZIP code
Home Address	City		ZIP code

Day Time Phone	Other Phone Number	Fax
Email Address		

Please indicate the services that you expect to provide (check all that apply):

- ❑ Other travel vaccinations (i.e. typhoid, hepatitis)
- ❑ Malaria prophylaxis
- ❑ Advice only for malaria prevention
- ❑ Prevention of traveler's diarrhea
- ❑ Counseling for travel risks
- ❑ Post-travel evaluation
- ❑ Full medical practice

I agree to comply with all guidelines established by the State of California, Department of Public Health pertaining to the use of the State Uniform Stamp. I understand that the stamp remains the property of the State of California, Department of Public Health and is subject to recall at the discretion of the Department.

Signature of Applicant Date

OFFICE USE ONLY

❑ Approved ❑ Denied

Date Received Date Stamped

Impression of Stamp	Please Mail To:
	Yellow Fever Vaccine Program **ATTN: Akon M. Walker** California Department of Public Health Immunization Branch 850 Marina Bay Pkwy., Bldg. P Richmond, CA 94804